

# Paediatric Implications of the Battered Baby Syndrome\*

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*'Let us speak less of the duties of children and more of their rights.'*

*Jean Jacques Rousseau—1712-78*

I very deeply appreciate the honour you have paid me by your invitation to deliver the Windermere Lecture. My sabbatical year of absence from the University of Colorado is just now coming to an end, and it is a splendid opportunity for me to thank all members of this Society who have helped me in my efforts during this year.

I coined the term 'The Battered Child Syndrome', in 1962, despite its provocative and anger-producing nature. I had for the preceding 10 years talked about child abuse, non-accidental, or inflicted injury, but few paid attention. At a gathering very much like this in 1962, describing in some detail the physical findings, both subtle and severe, of the battered child and at the same time beginning to point out some of the dynamics involved in child abuse, there did result a degree of public attention and, I might add, physician attention, which had previously not been possible.

In Denver we see about 40 new abuse cases each year. In the yearly hospital admission list of a medium sized paediatric service, some relative numbers of clinical conditions show the importance of the syndromes of 'abuse' and 'failure to thrive' (Table).

TABLE

*New Cases per Year (Children's Hospital, Pittsburgh)*

	No.
Phenylketonuria (PKU infants)	11
Wilms' tumour	6
Neuroblastoma	7
Cystic fibrosis (less than 3 years)	11
Leukaemia (0-16 years)	25
Abuse or suspected abuse	41
Failure to thrive	37

## Definition

The battered child syndrome must be thought of as only the extreme form of a whole spectrum of

non-accidental injury and deprivation of children. At one end of the spectrum is the child who is frankly battered and may have repeated serious injuries. These injuries often occur in a crescendo of increasing severity from mild bruising to subperiosteal bleeding seen on x-ray, to fractures of the long bones and ribs, to subdural haematoma with or without skull fracture. Then there are the children who receive repeated minor trauma or unexplained repetition of falls and bruises (the 'accident prone baby'), and finally children who are not receiving either physical or emotional nourishment and are simply put aside in an ultimate form of passive rejection. The concept stressed by us that young parents can attack their small child without being necessarily 'bad' or 'mentally ill' cause a great deal of consternation.

## Incidence

Nobody knows the true incidence of the extended syndrome but from prospective observations of families from all walks of life, I believe that it is as common as 6 in 1,000 live births. Reported cases in Denver and New York now range between 175-225 reports per million population per year. Provided these figures are representative, the annual number of cases in the U.S.A. would be 30,000-50,000. Considering that nobody knows what fraction of actual cases is now reported, the true frequency can be taken to be higher. For 500,000 new babies born each year in Great Britain there may be 3,000 cases each year of which half will be significantly injured and the other half seriously deprived. Radiologists and forensic pathologists have come to be very sophisticated in making this diagnosis, and our radiologists have found that roughly 25% of all fractures seen in the first two years of life are due to the battered child syndrome. In our casualty department, 10 to 15% of all trauma seen in children under 3 years of life were found to be due to this syndrome, quite regardless of the history given or the social class of

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the parents, provided a properly sensitive history was obtained in a non-accusatory way by an experienced person.

### Who Batters Children?

When I was a houseman 25 years ago I saw many bashed babies and I was taught that abusive parents were either drunk fathers or inadequate mothers, all from the lower social classes. It was only when Dr. Silver and I, between 1956 and 1960, saw a great number of parents who did not fit this stereotype that we began to reach out for a better explanation. For one thing, it was not true that battering parents came only from the lower social classes, as was so often believed. The poor do have more stressful crises in their lives, and they handle them with difficulty. And the poor are more likely by far to be reported, accused, and convicted. My favourite philosopher, Miss Sophie Tucker, used to say: 'I have been poor, and I have been rich. Rich is better.' In our own experience with over 400 battering parents, all social classes, all races, creeds, religions, and levels of education and of income are proportionally represented. Depending on the make-up of the group under study, findings vary. For example, in one public Denver hospital serving a population with high paternal unemployment and, therefore, increased exposure of unemployed fathers to small children, the ratio of mother to father battering is 1:1. In another public hospital serving a highly employed group we found that for 80 battering mothers there were only 20 fathers (4:1). Adoption is a middle and upper class phenomenon and, predictably, few adopted babies show up among studies limited to the poor, but among our group of well-off patients there is a

higher than expected incidence. Stepchildren of all classes are more at risk than natural children, and so are prematures.

In our understanding of the battered child syndrome, we have focused on families from the upper and middle social classes because we felt that individuals favoured by education and the usual amenities and not stressed by crowding, poverty, ill health, and poor education would give us more insight into the underlying dynamics of the disease. We have come to feel that perhaps 5% of battering families have one parent who has a psychosis which may be of a frankly delusional or depressive kind while some are 'encapsulated' as regards a specific child at a specific time. It is not easy for a psychiatrist to diagnose such an 'encapsulated psychosis' in a single one-hour session, and many visits, over a period of weeks, are often required to make a proper diagnosis. Children in these families tend to have bizarre injuries. Such was the case of Jody who was 4 years old when her parents brought her to Colorado General Hospital. She had suffered from severe abuse all of her life and showed one of the most severe cases of malnutrition that we had seen. She weighed only 7.7 kg and was covered with bruises and abrasions (Fig. 1). Radiological studies revealed fractures of the skull and arm and two fractures of her hands. She also presented a high intestinal obstruction due to a haematoma in the lumen of the duodenum. For years Jody's mother had expressed to her husband and other members of the family and community her concern about this child and the manner in which she was able to care for her. No one had been willing to accept this responsibility, and no help was offered the mother. Four sibs were well and happily cared for (Fig. 2).



FIG. 1.—Jody, on admission to University of Colorado Medical Center.



FIG. 2.—Jody's sibs.

The scapegoated child was the only one the mother saw as 'bad', indeed she was, and remained, the only one the mother saw as being like herself. Shortly after Jody was admitted to the hospital, the mother was told that we would not recommend that Jody be sent home because of our concern for her welfare. Without hesitation the mother in a very relieved tone stated, 'I would be more frightened than you if she were sent home.' Jody's progress in the hospital was dramatic (Fig. 3). During the



FIG. 3.—Jody, 5 weeks after admission.

six months after discharge she grew 15 cm and showed considerable developmental improvement. Parental rights were permanently terminated by the Juvenile Court and the child was successfully adopted. None of the remaining children was subsequently scapegoated.

Another 5% of parents appear to be aggressive psychopaths. These are individuals, mostly men, who beat everyone: their wife, their friends, their children, quite indiscriminately. They speak little and communicate through bashing people. Our therapeutic results in both these groups have been

dismal while the child remains in the home. We are left then with 90% of battering mothers and fathers who seem to have serious problems in mothering.

Professor Brandt F. Steele, who is our collaborating psychiatrist and a pioneer worker in this field, feels that basic in the abuser's attitude toward infants is the conviction, largely unconscious, that children exist in order to satisfy parental needs. Infants who do not satisfy these needs should be physically punished in order to make them behave properly. Further, this demand for satisfying behavioural response from the infant to parental need is highly premature and expressed very early in the infant's life. As an inevitable corollary, there is parental disregard of the infant's own needs, wishes, and age-appropriate abilities or inabilities to respond properly. It is as though the infant were looked to as a need-satisfying parental object to fill the residual, unsatisfied, infantile needs of the parent.

### Myth of Unfailing Love of Child

Let me stress here that while your country and mine are obsessed with teaching 'mother-craft', very little is taught to young girls and boys about 'mothering', and motherliness is thought, wrongly, to be instinctive and universal. By 'mothering', we mean the sensitive, generous, and individualistic approach to the young child by a very tender mother or father prepared to give promptly and predictably whatever the baby needs in the way of individual attention, food, and comfort. It is regrettable that our concept of mothering is so influenced by our idealized view of the mother as a madonna, sweetly smiling on her young child (Fig. 4). This madonna-like mother of infinite patience is in the mind's eye of many physicians and the public at large. But in fact, every parent knows better. It is unlikely that any mother or father can be loving and generous 24 hours a day, 7 days a week. The ability to be unfailingly generous to the child, particularly if the child is not easy to care for, varies widely. In our experience perhaps 20% of all young mothers have serious problems in mothering, sufficient to require a great deal of support on the part of husbands, health visitors, and physicians. Of this group perhaps 1 in 5 does not know how to turn on mothering ever, and in this situation functions of mothering are often taken on by other people in the family or else the child will receive insufficient mothering and be damaged for life. We must somehow learn to 'titrate' the amount of supplemental mothering a given child needs.

### Clinical findings of Extended Battered Child Syndrome

There is no longer any difficulty in diagnosing the blatant case, but what about the subtle clinical findings which seem to be missed again and again? Perhaps the most puzzling and important syndrome of infancy is loosely called 'failure to thrive', and in our experience in Denver, all the congenital and acquired conditions of paediatric pathology taken together account for only 80% of these cases. But



FIG. 4.—Raphael—*Madonna and Child*.

20%, the largest single group, are due to deficiency in mothering, either not enough food, or emotional neglect, or aversion. It is a serious, and often missed, form of the battered child syndrome. These children thrive in hospital where no normal child *should* thrive. They gain weight as they catch up on development rapidly. Where the parents had described the child as slow, clumsy, retarded, difficult, and generally 'sick', the hospital quickly finds the child to develop with tremendous speed, both in terms of physical and emotional parameters. He makes enormous strides in two weeks in the hospital while more esoteric causes of failure to thrive are sought. It does no good to

prove to the mother the child is indeed all right, since her seeing of the child as being *not* all right is an important diagnostic tool, and her inability to mother the child successfully is simply reinforced by the hospital demonstration that the nurses do better. I believe that *all* failure to thrive infants, that is, all children who leave their predicted growth and weight curves over a period of 6 to 8 weeks, should be placed in hospital for an experience in mothering by a mother substitute. It is helpful to try to admit the mother at the same time to see how mother and child interact, and, in part, to encourage her to enjoy and take care of the baby. In all these approaches our focus must be on the family, not just on the child. If we discontinue tonsillectomies and open the resultant vacant beds to the baby whose growth and weight curves have flattened for no particular reason, who does not smile or develop motor and social skills appropriately, we would gain tremendously in terms of preventing long range and often irreversible pathology and lasting human emotional and physical economic loss. Testing for phenylketonuria is far less urgent and the yield far less impressive. The decision that 'mental retardation' is the proper diagnosis should not be made by parents or physicians until an environmental change fails to show improvement. Often it does.

Among early and subtle physical findings are bruised cheeks, bites, small burns, lacerations, or tears in the mouth mucosa, particularly around the front dental ridge in connexion with shoving the bottle forcefully against the child's mouth. Fresh retinal haemorrhages are commonly seen in young children who have been shaken or received blows to the head and who often have no skull fractures. Often the baby suffers an inflicted injury during spells of protracted crying while he is acutely ill with, commonly, a respiratory infection or otitis. The distressed child, who is in obvious pain, may show no fractures on skeletal survey, and subperiosteal bleeds in the long bones will only be discovered by massive calcification revealed by repeat radiological examination two to three weeks later. Such routine follow-up x-ray examinations are essential to proper diagnosis.

One of the most common *prodromes* of the battered child syndrome is found in cases of mothers who bring the *normal* baby back again and again with non-existent complaints. New mothers who describe their child to us at variance with what we see are giving us an entirely different message which has to do with their fear that they will hurt their child unless something is done to intervene. It is common for doctors to ask mothers how the baby

is doing, not so common to ask her how *she* is doing, or if she is having fun. We may have thoughtful physicians who ask if the baby is difficult or upsetting to the mother, but we would not be likely to ask her if the child makes her angry, because anger or rage towards a new baby is not an acceptable emotion in our society. One of our key concepts is that love and hate go together, and it is possible to have the tenderest, warmest feelings toward a baby one minute and be extremely angry at it the next.

### When Does Battering Occur?

The dynamics of the *immediate* outbursts towards the child are often related to the very quality of mothering being brought into question by the child's behaviour. The baby cries and the mother feeds it, it cries more, the mother changes it, it still cries, and there comes that dreadful moment in every parent's life when love and desire to care for the child is mixed with incredible disappointment, anger, and even hate. It is surprising not that there are so many battered babies but that there are so few. Happily, there are many safety valves which prevent batterings in most situations. These include the capability of the mother to withdraw at this moment of great rage from the child by closing the door, finding help from an understanding husband or neighbour, or communicating with some other person who can help by phone. Typically, the battering parent cannot withdraw from the child who cries because the crying child is saying to her (the parent) something quite specific. 'If you were a good mother, I would not be crying like this'. At the moment of attack, the child is seen as 'bad', 'naughty', 'wilful'—in fact, exactly as the attacker was viewed by his or her parent. In this sense, the attack on the child is an attack on the person of the attacker himself—a form of suicide.

The bashing often relates to the immediate feeling of frenzy about the inability to stop the crying, but other triggers may exist, including soiling, or rejection of feedings.

### Diagnosis

When we see the child who has been injured there is often a delay of hours between the injury and the time medical help is effectively sought. Delay in seeking medical help is not so much based on the parent's fear of discovery as on blocking of the painful event and a hope that denial will mean that nothing, in fact, has happened. Such delay in time should be noted, but not assumed to be malicious in origin. When medical help is sought, it often is with great feelings of concern. This in

itself is often disarming to the physician who believes that a parent who hurts his child would be unlikely to be so obviously concerned for the child's welfare. Let me stress again that battering parents generally love their child, often not very well and perhaps too much. There is generally a marked discrepancy between the history given and the findings. With any injury that is not easily explained, or has been repetitive, a skeletal x-ray survey must be done, looking particularly for datable fractures with different phases of healing or, in the absence of fractures, looking for calcification of subperiosteal bleeds in the long bones or metaphyseal separation.

Physicians are trained to believe in the history given by parents, but in the context of childhood accidents we need to be aware of a broad spectrum of information in addition to the specific history given for the injury. In every childhood accident the physician must look for (1) a discrepant, vague, or absent history of the injury; (2) delay in seeking medical help; and (3) whether there is the potential for abuse in the family setting. Useful information will often only be obtained by a leisurely home visit made by a skilled health visitor or social worker.

Physicians love to talk of the 'grey area' of the diagnosis of the battered child. There are some cases where a single injury is in doubt, though in many instances even the single injury can be diagnostic and, obviously, one should not wait for a second injury if the first can be properly diagnosed. Here a leisurely and sympathetic psychiatric evaluation of the parents often yields useful information. Such information includes answers to these five questions: (1) How does each parent see this child? (2) How much and what do they expect of this child? (3) How were both parents raised? (4) Was there a personal or family crisis at the time? (5) Do the parents have effective help in crises from friends or family—a rescue operation? These must be considered by physicians and by the courts as important and hard data comparable to x-rays and photographs.

If on a skilled interview there emerges a picture of an emotionally deprived childhood in one or both of the parents, if the child is pictured in a negative way, if the parent's attitude is one which is too demanding and full of unreasonable expectations, and if there was a crisis, then all this information can be added to the medical 'grey area' and intervention can proceed on firmer ground. This cannot be done, in most cases, by the paediatrician alone, nor, however, should it be simply turned over to the child psychiatrist or the social worker. All professionals together are needed to get a consensus in consultation, to consider what the

family pathology is, and what might best be done. The decision is often one of life and death as far as the child is concerned. *Sharing* the decision will decrease the anxieties of all professionals and, in time, lead to certain improvement in their skills and judgement.

This country rightly has had a long-standing love affair with the detective story. The temptation is certainly large for the physician to decide who the culprit is. In fact, I see much time wasted on trying to find out 'who did it'. It is now clear to us that the important question for the physician to answer is 'did something happen?' If he thinks something happened he must then assume that he is dealing with at least four sick individuals: the baby, the father, the mother, and himself. Each in their own way are debilitated by the event and need treatment. For every battering parent mother or father, there is a spouse who abets, condones, and covers up the battering. Marriage partners tend to be very protective of one another. Often they are both severely deprived individuals who cling together for very inadequate support.

The potential for child abuse is greatest among the parents who were both emotionally deprived through lack of early mothering. These parents seek to get an unrealistic amount of love, gratification, and satisfying care even from their very small children.

'I've waited all these years for my baby and when she was born she never did anything for me.'

'When she cried it meant she didn't love me; so I hit her.'

The young child shown in Fig. 5 has the knowing and wise look of a much older person. He always patted his mother's knee to comfort her when she cried or was upset. This is a classic example of the role reversal of the child acting in a motherly fashion toward the distressed mother.

Battering parents tend to see the child not as he is but see him as they themselves were seen by their parents early on—as slow, bad, selfish, defiant, hard to discipline. These parents often demand the impossible from very young children. Characteristically, the parents tend to be depressed and isolated and lack a lifeline to a giving parent, friend, or professional person who can help in moments of crisis.

Some children may be more vulnerable to abuse than others. Among them are the hyperactive and precocious, the premature, the adopted, and the step-child. In addition some children from the earliest day seem to be singularly unrewarding to the mother no matter how hard she tries, though it is

not easy to know in a given situation whether the primary problem lies mostly with the baby or with the mother. The act of battering is a final common pathway. For it to occur there must be (a) the potential for abuse, (b) the characteristics of the particular child as seen by the particular parent, and (c) there must be a crisis.

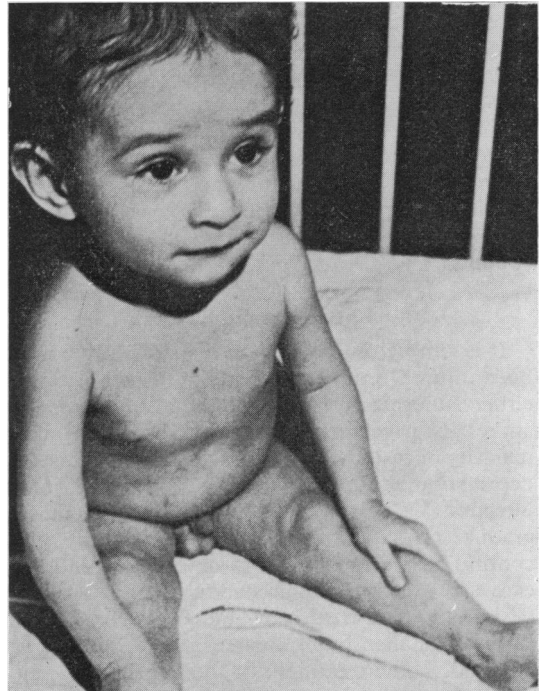


FIG. 5.—This young child has the knowing and wise look of a much older person.

### Early Management

The diagnosis of battering must be considered in all trauma to small children, and, if it is suspected, even if the injury is not serious and would otherwise not require hospitalization, the child should be admitted to the hospital for clarification of all questions mentioned above. Physicians should not accuse parents of inflicting the injury since premature confrontation invariably leads to reactions of extreme anger, which get in the way of proper diagnosis and treatment. Hospitalization is explained as a 'check-up' or 'to be sure the baby isn't badly hurt'. Then follow sympathetic inquiries about difficulties with this child and with life in general. Most parents who injure their children want help, and if sympathetic help is offered without resorting to threats or accusations, the parents are usually co-operative. A complete

skeletal x-ray survey and developmental evaluation of the child and leisurely psychiatric evaluation of both parents can proceed before appropriate intervention is arranged.

The resistance of physicians to the diagnosis of the battered child syndrome, particularly in its mild form, is overwhelming. Physicians will go to enormous lengths to deny a possibility of physical abuse of a child by his parents. Rare bleeding disorders, osteogenesis imperfecta tarda, obscure endocrine diseases, 'spontaneous' subdural haematoma, or malabsorption syndrome are invoked. All are an attempt to deny the fact that failure to thrive or injuries could be due to pathological mothering. If this is to be overcome there is great need to provide the physician with the tools required to handle competently a complex and upsetting situation.

### Later Management

It is simply unsafe to have a small child who has been injured returned to parents, if one of them is either suffering from major mental illness or is an aggressive psychopath. On the other hand, in the majority of cases, where one is dealing with maternal deprivation of the parents it is often possible to introduce a therapeutic person while allowing gradual return of the child to the family under continuing treatment. 80% of children under our care are back with their parents within 8 months of initiation of treatment, but 5% have parental rights permanently terminated and the children are adopted. The treatment of the deprived parent is another attempt at 'mothering', so that emotional dependency on the child and isolation are lessened and feelings of trust are developed.

It is not easy to take on another adult as a friend offering love and support and reliable, predictable human resource. These patients tend to wear one out emotionally, they are challenging, and often almost ask to be rejected. It takes a high degree of generosity to permit a marked early dependency upon the therapist which is required in such treatment. In our experience while professional training does not hurt, it does not seem to help either. We have had very excellent results with therapists who were psychiatrists, social workers, nurses, paediatricians, and our untrained 'foster grandmothers' and 'mothering aides'. I might add, that we have had some very bad luck with some highly trained professionals who simply are not prepared to give of themselves in this therapeutic experience of loving a very deprived parent.

Treatment consists of weekly or twice weekly home visits devoted to patient listening, under-

standing, and uncritical approval, with focus on the parent's need rather than on the child's. It must be stressed that it is our experience that if the parents' basic needs are met the child will be safe. Interpretive psychotherapy has, in fact, very little to offer to these very damaged parents, and it is generally dangerous and contraindicated. Early on they tend to do better with male than with female therapists, but we provide a choice and we allow the patients to go back and forth between members of our team. In any event we provide a telephone lifeline 7 days a week, 24 hours a day for moments of stress.

The plan of treatment once the diagnosis is suspected is: (1) child admitted to hospital for diagnosis; (2) child temporarily separated from parents for protection; (3) begin plan to make home safe for child's return through 'mothering' therapy; and (4) gradual return of child to home or family foster care.

### When is it Safe to Return the Child?

The goals of treatment are limited. Battering parents are usually emotionally deprived and damaged. To expect mothering therapy to produce a mature, trusting, and warmly loving person is to expect the impossible. If early very great dependency on the therapist is followed by emotional growth of trust and gratification of needs by other friends, enjoyment of the child, improvement of self-image, and the use of life-lines in moments of crisis, the child is safe to return. But treatment is essentially never terminated by us, we remain caring friends though frequency of regular contact may lessen considerably over 1 to 3 years. The door is always open, and in situations of new stress, such as a new pregnancy, parents may require increased support. Much improvement is often seen in only 3 to 6 months and intensive care rarely lasts more than 8 months.

### Predicting and Managing Insufficient or Pathological Mothering

How is it possible to predict mothering ability and to assist in mothering where it seems to be deficient, since it certainly is not an all or none proposition? We think there are certain useful leads in trying to pick out women who have serious difficulties in mothering. These can often be discovered in the prenatal period, begin to become quite obvious in the immediate postpartum period, and are often well recognized by the time the child is 6 to 8 weeks of age. Clearly, health visitors, midwives, general practitioners, and paediatricians



may have an opportunity to suspect what may be one of the most important diagnoses in paediatrics. We have come to feel that certain questions may be highly predictive. They are (1) does your child cry a lot? How do you manage your baby's crying? Does it upset you when you are unable to stop the crying or comfort your baby? How do you feel inside when the baby cries? Does it ever make you feel like crying? (The answers to these questions relate to anxiety and anger or feelings of despair.) (2) Does it upset you when you are left alone? Have you ever been afraid to be alone with your baby? (During stressful periods parents may express many fears of being alone.) Can you usually call someone to help at these times? (Absence of life-line.) Does it make you anxious to have someone watch you feed your baby? Do you ever get the feeling that others are critical of how you feed or take care of the baby? Do other people understand the problems you have with your child? (These questions reveal the amount of pressure these people have felt all their lives to respond to somebody else's needs.) When do you feel children are old enough to understand what is expected of them? How well do you feel your children understand you? Can they tell when you are upset and do they help? (These reveal how the parents may be turning to a very small child for satisfaction of their own needs.)

If we understand that mothering will not be turned on ever in some situations no matter how hard one tries, we will then stop pushing some babies at their mothers who tell us, with every verbal and non-verbal way they know how, that they cannot and will not take care of their child. It is clear to me that one of the urgent needs in our society is to provide, without waiting for injuries, for the baby who cannot receive all its mothering from the biological mother. A great variety of therapeutic approaches is needed. For the mother who can be competent 14 but not 24 hours a day at a given moment in time, there should be day help, day nurseries, mother's groups. In moments of personal or family crisis, a 'safe place' should be known to exist in each community where, on the decision of the mother alone, and with no delay or red tape, the child could be received for a few hours or a few weeks.

But when that is all done there will still be mothers who will not be able to turn on mothering no matter what support is given. Society will have to accept the fact that mothering does not occur spontaneously because of the biological fact that the child has been through the birth canal. Excellent mothering can occur from women who have

never had a baby and, of course, from the vast majority of fathers as well. On the other hand, we know mothers who have had seven or eight babies, none of whom has received even minimum mothering. We seem to say to these mothers: 'you have had your fun, now take care of it.' Along with this there is a terrific fear on the part of society that if mothers were free to dump their child who is for one reason or another not wanted, there would be thousands upon thousands of unwanted babies deposited at the doors of local authorities to be cared for by society. It is a serious moral question as to whether in the long run it would not be wiser to provide these children with well-paid foster homes. It is regrettable that ever since it was feared some foster homes were becoming a business rather than a vocation, foster parents are offered so little money that many very suitable, but not well-off, foster mothers are working in industry when in fact they should be earning the same kind of money doing what is socially a much more important job. Clearly, we must make good foster care a socially and financially rewarding profession in the years to come.

### **The Law and the Battered Child**

I strongly favour a reporting system of suspected inflicted injury and of 'failure to thrive due to deprivation', and the responsibility for such reports should be shared widely by physicians, health visitors, social workers, and teachers. I propose that the question of 'wilful' infliction of the injury should be entirely deleted in the report because these injuries are rarely premeditated or wilfully inflicted. Nor do I feel that the determination as to who has inflicted the injury should be involved in the filing of a case brought to obtain a supervisory order on behalf of an injured child, because, almost without exception, both parents are involved. It is nothing less than tragic that Children's Departments often fail to file cases for supervision or 'fit person' orders because they feel that they will 'lose' the case because there is insufficient evidence. Often physicians refuse to testify for Children's Departments for fear of loss of time or reputation. Magistrates are, therefore, seeing less than 5% of abuse or neglect cases for judgment because the case is prejudged by those who feel that, on balance, it is better to maintain some relation with the family than to intervene unsuccessfully in a family court. In our experience it is only necessary to show that the child is at risk to obtain an order of supervision which can initiate treatment and this is the goal of intervention.

We have come to feel that criminal penalties for



battering parents are absolutely useless. Of six confessed male batterers who went to prison, three have reinjured their child, one has not, and two have not been found. Prison is the kind of punishment which battering parents can readily understand since they have always viewed the world as a punishing world and putting them into prison confirms this. In a sense, if child abuse has occurred and has been allowed to recur and recur again, the fault is upon us in the health professions who have often had many chances at intervention and have failed to intervene effectively.

Parents do not wish to hurt their child even though they do so repeatedly. If you intervene so that they cannot hurt their child, by temporary or prolonged separation, and initiation of treatment with or without the use of the courts, you do something *for* rather than, as is often believed, *against* them. Parents are often most grateful in months to come for this aggressive intervention which goes so much against the grain of physicians raised in the concept that parents are essentially free to raise their children as they see fit.

There are three almost sacred sayings in the western world which stand in the way, I like to think, of progress in this important area. The first is: 'spare the rod and spoil the child'. It is true that discipline and necessary control are often given as reasons by parents for battering even very young children. It is certainly true that corporal punishment is an accepted way of raising a child in the western world and it is, therefore, often felt by physicians and magistrates that injuries in the course of correction are to be dealt with as unfortunate accidental events. 'He didn't know his strength.' I submit that these are oversimplifications and that aggression of an overt kind as a way of life between adult and child is serious in its eventual import on the child as he goes to adulthood. Among delinquents who are aggressive there are many more histories of batterings than among delinquents who are not aggressive, and among our most violent citizens are a high proportion who have been severely battered as infants. Often they view their early childhood with great pride as being desirably strict, but the battered child grows up to be the battering parent. It is regrettable that strictness, discipline, battering, get mixed up together when these matters are considered.

The second saying, 'be it ever so humble, there is no place like home', is one that is in a sense rediscovered by those in the field of psychiatry and child care who are appalled at the spectre of babies raised in residential nurseries without a firmly

identifiable mother figure. It is clear that many social workers have simply misread the message which has come from workers such as Bowlby. It does not have to be the biological mother who mothers the baby though there has to be a mothering person for every child.

The third is 'a man's home is his castle'. Intervention in a person's way of raising children is a delicate matter. I am sensitive about the rights of parents 'to be left alone'. The right of privacy is one's own determination about what information about ourselves we will share with others. An individual's information about himself represents a large part of what has been called his 'moral capital'. Some of this information, by right and necessity, he wants to keep to himself. Some of it he will share with his family and friends, some he will admit to the impersonal organizations he must deal with in his daily life. Clearly, the rights of the child for reasonable care and protection must be balanced against the right of parents to be free to raise their children in their own image. But the child does no longer 'belong' to his parents, he belongs to himself in the care of his parents unless he receives insufficient care or protection.

We do force all parents to present their 5-year-old child to society for an attempt at basic education under penalty of prison for the parents who refuse. Why would it not be right to force each parent to present their infant to society in the form of an understanding and properly trained health visitor for required basic supervision of physical and emotional health at regular intervals?

### Conclusion

Paediatricians need to concentrate once again on early childhood! After our early preoccupation with infant care, with sound advice about feeding and immunization, we rapidly branched into the important problems of childhood subspecialization and produced much essential information in the pathology of organ systems which differ from adult medicine. These scientific contributions in paediatrics have been greatly to the benefit of children and of adults too. But we all agree that the physical and emotional growth and development of young children proceeds on a time-table which is rarely disturbed for long without a good chance of permanent retardation in body and soul. Mothering is one essential requirement of such normal growth. Disturbances in mothering must be sought, predicted, and corrected, if possible, with persistence.

We have a traditional concern with prevention of disease and a concern that children reach their

highest potential. We must now bring to bear our intellect and our love for children to the cause of helping the battered child and his family, for the well-being of children in this generation and of their children in generations to come.

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